STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM HC-5
EMPLOYEE NOTIFICATION TO EMPLOYER
FOR CALENDAR YEAR 2012

Instructions

Instructions to Employee: This form is to be used for the following purposes as provided by the Hawaii Prepaid Health Care Act and Administrative Rules: (A) If you work for two or more employers, you must notify each employer whether the employer is the principal employer (the employer responsible for providing health care coverage) by checking item 1, or the secondary employer by checking item 2. (B) If you are claiming exemption or waiver from health care coverage, indicate the reason in the appropriate block under item 3 or 4. (C) If you are changing your principal and/or secondary employer designation, or if you are terminating your exemption, complete item 5.

Note: This form need not be filed if (1) you work for only one employer and your employer provides you health coverage, or (2) you work less than 20 hours per week for your employer.

To determine who would be the principal employer, Section 393-6, Hawaii Revised Statutes explains that (1) the principal employer shall be the employer who pays you the most wages; or (2) if one of the employers, who does not pay you the most wages, employs you for at least 35 hours a week, you shall determine which of the employers shall be your principal employer.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person
Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Delivery via Fax
Department of Labor and Industrial Relations, Disability Compensation Division
(808) 586-9219

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FORM HC-5 EMPLOYEE NOTIFICATION TO EMPLOYER FOR CALENDAR YEAR 2012

Employer Information

Employer Name	DOL Account No. - -
Address	Telephone No. ( )

In accordance with the provisions of the Hawaii Prepaid Health Care Act (Chapter 393, Hawaii Revised Statutes), this is to notify you that: [Check appropriate box(es)]

☐ 1. Of the two or more concurrent employers that the undersigned works for (at least 20 hours a week), you have been selected as the **principal** employer and are therefore required to provide health care coverage for the undersigned (Section 393-6).

☐ 2. Of the two or more concurrent employers that the undersigned works for (at least 20 hours a week), you have been selected as the **secondary** employer and are therefore relieved of the responsibility to provide health care coverage for the undersigned until you are otherwise notified (Section 393-16).

☐ 3. I am **exempt** from health care coverage because I am (check box below to indicate reason)(Sections 393-17 and 393-22):

- ☐ a. Covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents.
- ☐ b. Covered as a dependent under the following prepaid health care plan entitling the employee to the health benefits required by Section 393-7 _____, (attach copy of plan if not an approved plan by HMAA, HMSA, KAISER, UHA or UHC.)
- ☐ c. A recipient of public assistance or covered by a State-legislated health care plan governing medical assistance.
- ☐ d. A follower of a religious group who depends upon prayer or other spiritual means for healing.

☐ 4. I waive coverage from my employer's health care plan; in lieu I have obtained a plan from _____ (name of health care plan contractor) which satisfies the Hawaii Prepaid Health Care Act (attach copy of the plan and send to the Disability Compensation Division). I understand this individual waiver is binding for one year (Section 393-21).

☐ 5. The coverage exemption previously indicated in items 2, 3 or 4 is no longer applicable; you are therefore required to provide health care coverage for the undersigned (Section 393-18) effective _____ (give date).

Print Name _____

Employee Signature	Date
Address	Telephone No. ( )

Instructions to the Employer: Enter your firm's Department of Labor (DOL) Account Number in the space provided. Provide coverage as required by 1 and 5 above. Retain the original and give a copy to the employee. A copy is to be sent to the Disability Compensation Division only when the employee selects exemption #3(b) or individual waiver #4 or upon request by the Director. This form must be kept for two years.
This notification must be renewed every December 31. (Sections 393-17 and 393-22).

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.